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CASP/Faculty of Humanities and Social Sciences Policy Labs Project Executive Summary April 2020

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Aims of the project

Using Action Research – which returns the focus of inquiry to the local context (Stringer 2014:xi*) - we aimed to develop a Policy Lab to look at and solve social policy issues in a new way. We received a favourable ethical opinion from the Bath Social Science Research Committee on 17/02/20 REF: S20-009. Data collection was taken throughout the process to develop thinking around a best practice policy lab model.

Policy Labs are different to focus groups or other forms of discussions since they seek to communicate with a group of people with interests in a particular issue over an extended period of time. Policy Labs also use previous research on particular issues to inform the discussions.

In our Policy Lab model, service providers (health and local council), as well as service users and their carers, are important participants to ensure solutions to issues are based on real-life experiences. Holding decision-makers to account on Policy Lab outcomes is also central to its purpose.

COVID-19 prevented the project from delivering all events as planned, but the process of building the Policy Lab team, designing the events and developing the networks and contacts to support the events has enabled us to start work on how best to do Policy Labs. Results from our quantitative evaluation of the process were positive and we have learnt that a more deep-dive qualitative evaluative approach would help our design process. We therefore intend to build in a more iterative evaluation that measures confidence of participants in the Policy Lab model to enact policy change at different stages of the process including baseline measurement.

Engaging External Partners with the Policy Lab project

Healthy Ageing, the first topic to be presented, attracted a wide range of ideas from key statutory agencies in Local Government and the NHS. Several leading colleagues expressed support and enthusiasm for the proposals and committed to attend and contribute to the agenda. The pandemic prevented all these commitments coming about at this stage but there was a strong appetite to become involved in the project going forward - extending the reach to other public policy topics.

Involving Service Users in the Policy Labs

There was considerable interest among service users and NGOs representing service users to attend and participate in the Policy Labs. At the Bath event which did take place, service users were key contributors. We are confident of building on this progress in further events in the coming year. The following two-page summary gives you a flavour of discussions at the Policy lab on Health Ageing

– and the solutions we came up with. Once we have been able to complete the other two Policy Lab sessions on Health Ageing, we will combine the responses and feedback our findings to local government, creating an on-going dialogue with them to see how such solutions can be put into practice.

Healthy Ageing Policy Lab - BaNES, Widcombe Social Club, 17 March 2020

Initial presentations and discussions:

Following a presentation on the context of Healthy Ageing, the Care Act of 2014 and the Policy Lab (PL) process, the group raised the issue of older people having to stay in hospital longer than was required. Hospital can be the most dangerous place for older people; longer stays in hospital often result in more health and social care needs being required post-hospital discharge. This can stem from a lack of availability of appropriate social care e.g., convalescent hospitals, health visitors, home care support. Reduction in social care funding has exacerbated this problem and there is currently insufficient medical and health care staff to provide a reasonable system to cope with the increasing requirement from the ageing population. COVID-19 will increase stress on a system already under stress regarding care for older people.

There is a need for much more longer-term planning for older people rather than the current 2-3 year timescale, including more support and resources for prevention through attention to health during life pre-65 years, which should translate into 'ageing better'. Early intervention regarding health needs is better than the necessity for late responses when those needs have become critical. Too many decisions have to be made at the point of crisis.

- 90% of an individual's healthcare is needed in the last 12 months of life. Earlier intervention should mean the unhealthy stage of life could shorten enhancing wellbeing in later life.
- fragmentation of budgets across provision for older people is a problem. Earlier intervention could help budgeting. The introduction of personal budgets was an attempt to assist in this respect yet the choices people have to acquire social care have decreased.

Issues identified regarding lived experiences of people in the region

Due to the reduced number of attendees, delegates separated into 2 groups and each was asked to write down the issues they thought important regarding healthy ageing based on their own personal or professional experiences. These were then discussed and sub-categorised into the group's top issues (post-it notes were stuck on flip chart paper). These were then presented and discussed by all in a feedback session. Two key themes were identified and one each of these topics was then discussed by the individual groups. The two main themes identified were **'Inappropriate Medicalisation'** and **'Social Isolation'**. Each group then discussed their theme in more detail, linking it to the research findings already discussed in the first part of the Policy Lab, and fed back their suggested ideas and solutions to the whole group in the final feedback session. The following bullet points summarise the discussions:

Key theme 1: Inappropriate medicalisation of older age (The following paragraph summarises bullet points written on the Post-it notes and subsequent discussions).

There was a sense that older age had been 'medicalised' with a focus on older age 'health issues' that need medical intervention. This has led to more demands on hospital care for medical issues that could be dealt with more locally or within the community if the appropriate support had been available. Yet the demise of local hospitals meant that this was not possible (e.g. Bradford-on-Avon had no 'cottage' hospital yet there is a population of 11,000 people, many who are older; yet there is little access to support for both ongoing medical issues as well as chronic illness e.g. dementia).

It was also argued that although there were more TV programmes about ageing and good health, there was a need for attitudinal/cultural changes were needed to cope with the growing older population.

This would involve an understanding of what constitutes good health in the very old; how families need to adapt to this (e.g., via family sharing/granny flats), and more open discussion around whether 'old people's homes are a good idea' as well as the subject of end of life. It was acknowledged that COVID-19 may heighten awareness of such conversations. Adapted values would also include providing more informal 'support' (in consideration of the needs of informal carers) reducing the need for formal care.

Solutions:

Earlier preventative measures including social care which should be linked more (and have the same status) to the NHS; making access to GP surgeries easier for older people in particular. Post-illness evaluations of social care (as part of the existing hospital leavers' assessments and care plans) would be useful to indicate how much social care is available for older people. A reinstatement of state-provided recuperation centres (similar to the old cottage hospitals) and health visitors would enable a stepped approach from acute care for people to become independently home-based thus preventing re-admissions to hospitals thereby reducing hospital bed blocking. Creating a role which is part carer, part district nurse employed by GPS was another option discussed. Improved care and training for professionals which normalised old age was key to these solutions.

More Community-based solutions need to be underpinned by government support include more informal intergeneration activities and improved signposting to other services and community groups. This would hopefully prevent hospital admission especially for those on the edge of society.

Key theme 2: Social isolation and exclusion

Discussions around rural areas versus urban areas highlighted how new housing projects were often remote from towns and facilities and contact with children and young people is often lost. This is particularly stark for those who rely on non-digital communication (especially those over 80 years old). Such inequality also extends to health and social issues (if someone has money, they can get faster medical care and engage in more activities). Older people with less resources and living in deprived areas may have less opportunity to engage socially. However having money does not preclude them from loneliness and social isolation (many older people have things too but no one to do them with). The physical, emotional and social difficulties of caring for a partner who may be the same age or older than the carer was highlighted. Accessible, reliable, affordable transport is key to combating social isolation. The issue of death and bereavement also linked into this discussion; that isolation can also be physical (e.g. the loss of personal touch/intimacy) and that space and time are needed for older people to reflect on their own experiences of bereavement.

Whilst there had been some national discourse around attitudinal change towards older age through campaigns the group discussed the need for more positive thinking about older age; the fact that older people include an articulate population; that older people wish to feel needed and valued and should be viewed as a resource for volunteering rather than as a burden (active ageing=aging well). More intergenerational programs would help move this agenda forward – for example, intergenerational co-housing; intergenerational face-to-face interactions.

Solutions:

It was agreed that more proactive investment in local services was needed to support, fund, create, and promote accessible volunteering for older people including in e.g. local government, childcare and the arts. In tandem, people of working age should be able to get paid time off to volunteer under corporate social responsibility schemes. Social housing that includes intergenerational aspects should be linked with affordable, accessible public transport (lessons learnt from the Netherlands) as well as community radio stations in local areas. All of these measures would need to be underpinned with awareness campaigns re-rights to services and care for both older people and their carers. There needs to be a cultural shift so that older people are not socially ostracised by other age groups and older people are valued as important members of society with a lot to offer.